No. 92-315

(3)

Supreme Court, U.S.
FILED
OCT 21 1992
OFFICE OF THE CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1992

CESAR A. PERALES, COMMISSIONER, NEW YORK STATE SOCIAL SERVICES, PETITIONER

v.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION

KENNETH W. STARR
Solicitor General
STUART M. GERSON
Assistant Attorney General
BARBARA C. BIDDLE
MARC RICHMAN
Attorneys
Department of Justice
Washington, D.C. 20530
(202) 514-2217

[BEST AVAILABLE COPY]

QUESTION PRESENTED

Whether, in the case of needy patients who have been enrolled by the State in Part B of the Medicare Program, a State may limit the reimbursement paid to doctors and hospitals to the amount covered by Medicaid.

TABLE OF CONTENTS

	Page
Opinions below	1
Jurisdiction	1
Statement	2
Argument	7
Conclusion	9

TABLE OF AUTHORITIES

Cases:

Chevron U.S.A. Inc. v. *NRDC, Inc.*, 467 U.S. 837 (1984)	4
Samuel v. *California Dep't of Health Services*, 570 F. Supp. 566 (N.D. Cal. 1983)	7
Schweiker v. *Gray Panthers*, 453 U.S. 34 (1981)	7
Simon & Schuster, Inc. v. *Members of the New York State Crime Victims Bd.*, 112 S. Ct. 501 (1991)	9

Statutes and regulation:

Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 301(a)(1), 102 Stat. 748	3
Social Security Act, 42 U.S.C. 301 *et seq.*	4, 5
42 U.S.C. 1320a-7b(d)	2
42 U.S.C. 1395*l*(a)(1)	2
42 U.S.C. 1395*l*(b)	2
42 U.S.C. 1395v	2
42 U.S.C. 1395w-4(g)(3)(A) (Supp. II 1990)	8
42 U.S.C. 1395cc(a)(2)(A)	2, 4
42 U.S.C. 1396a(a)(10)(E)	6
42 U.S.C. 1396a(n)	6
42 U.S.C. 1396d(p)(3)	6
N.Y. Comp. Codes R. & Regs. tit. 18, § 370-7.7 (1990)	3, 4

Miscellaneous:

H.R. Rep. No. 247, 101st Cong., 1st Sess. (1989)	8

In the Supreme Court of the United States

OCTOBER TERM, 1992

No. 92-315

CESAR A. PERALES, COMMISSIONER, NEW YORK STATE SOCIAL SERVICES, PETITIONER

v.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-34a) is reported at 954 F.2d 854. The opinion of the district court (Pet. App. 35a-48a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on February 3, 1992. A petition for rehearing was denied on May 20, 1992. The petition for a writ of certiorari was filed on August 18, 1992. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Persons who are at least 65 years old or disabled and also meet other eligibility requirements are automatically enrolled in Part A of the Medicare program, a hospital insurance plan. Persons who are covered by Medicare Part A (and certain other persons) may purchase supplementary insurance for certain other medical services under Part B of the Medicare program by paying premiums to the Supplementary Medical Insurance Trust Fund. Under Medicare Part B, the federal government generally pays 80% of the "reasonable charges" for covered services. The patients are responsible for an annual deductible and the remaining 20% (the coinsurance). See Pet. App. 4a; 42 U.S.C. 1395*l*(a)(1), 1395*l*(b), 1395cc(a)(2)(A).

Medicaid is a need-based program funded by the federal and state governments; the federal government always pays at least half of the cost of the program. Under Medicaid, doctors and hospitals receive a specified sum set by the State for covered services, which is almost always less than the "reasonable charge" for the services under Medicare. Doctors and hospitals must accept the Medicaid sum as payment in full, and may not seek to recover from patients the difference between the Medicaid payment and their "reasonable charges" for purposes of Medicare. See Pet. App. 4a-5a; 42 U.S.C. 1320a-7b(d).

Some persons (such as elderly poor persons) are entitled to coverage under both Medicaid and Medicare Part A. Congress has provided that States may enroll those "dual eligibles" in Medicare Part B by paying the insurance premiums on their behalf.

See Pet. App. 5a; 42 U.S.C. 1395v. In addition, Congress in 1988 mandated that States participating in the Medicaid program purchase Medicare Part B coverage for certain other needy persons; those persons are called "qualified Medicare beneficiaries" or "QMBs." See Pet. App. 7a; Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 301(a)(1), 102 Stat. 748.

At issue in this case is how much doctors and hospitals will receive for medical services rendered to dual eligible patients and QMBs when (as is usually the case) the amount payable under Medicaid is less than the "reasonable charges" for the service under Medicare. For example, the Medicaid fee for a service might be $50 although the "reasonable charge" for the same service under Medicare is $60. If a State did not enroll a dual eligible patient in Medicare Part B, it would pay $50 (the Medicaid fee) to the service provider, who would be barred from obtaining additional reimbursement from the patient. If the State enrolled the dual eligible patient in Medicare Part B, the federal government would pay $48 (80% of $60, the "reasonable charge" under Medicare) to the service provider. Under the New York regulation that is at issue in this case, N.Y. Comp. Codes R. & Regs. tit. 18, § 370-7.7 (1990) (*reprinted in* Pet. App. 50a-53a), which was approved by the Health Care Financing Administration (HCFA) in the Department of Health and Human Services, New York would pay an additional $2 to the service provider, who would be barred from seeking to collect any additional amount from the patient. Thus, under New York's regulation the service provider would receive a total of $50 (the Medicaid fee) for the service. If the dual eligible

patient were a regular Medicare Part B participant, the federal government would pay the service provider $48 and the service provider could seek to collect an additional $12 from the participant, for a total of $60 (the "reasonable charge" under Medicare). Prior to the adoption of § 370-7.7 in 1987, the State would have paid $12 on behalf of the dual eligible patient in addition to the federal government's payment of $48. Thus, before 1987, service providers in New York would have received $60, rather than $50, for the service. See Pet. App. 6a-7a.

2. The plaintiffs—a provider of hospital services, a physicians' association, and individual physicians who treat Medicare and Medicaid patients—brought this lawsuit claiming that the regulation New York adopted in 1987 is contrary to the Medicare and Medicaid provisions of the Social Security Act, 42 U.S.C. 301 *et seq.* The district court dismissed the action, holding that the Secretary's approval of the New York regulation reflected a permissible construction of the Social Security Act and was therefore entitled to deference under *Chevron U.S.A. Inc.* v. *NRDC, Inc.*, 467 U.S. 837, 842-844 (1984). Pet. App. 35a-48a.

3. A divided panel of the Second Circuit reversed. Pet. App. 1a-34a. It held that the New York regulation conflicts with the Medicare program's provisions for hospitals and doctors to be paid 100% of their "reasonable charges." *Id.* at 9a. The court explained that 42 U.S.C. 1395cc(a)(2)(A) expressly provides that a health care provider "may charge" a Medicare Part B patient "an amount equal to 20 per centum of the reasonable charges for such items and services * * * for which payment is made under [this subchapter]."

The court noted that the statute contains no exception for dual eligible patients or QMBs. Pet. App. 9a, 10a.

The court of appeals rejected the argument of the Secretary of Health and Human Services that dual eligible patients and QMBs are primarily Medicaid patients, so that service providers should be compensated at the Medicaid rate rather than the Medicare Part B rate. The Secretary's argument was based on the fact that those patients are enrolled in Medicare Part B by the State because they are needy. In response to the Secretary's argument, the court noted that the federal government reimburses doctors and hospitals for services provided to dual eligible patients and QMBs at 80% of the Medicare rate rather than the Medicaid rate. Pet. App. 10a. The court added that health care providers may treat uncollected Medicare cost-sharing amounts, including those from dual eligible patients and QMBs, as bad-debt expenses, which, in its view, supports the conclusion that dual eligible patients and QMBs are primarily Medicare Part B patients rather than Medicaid patients. *Ibid.* The court also pointed out that the legislative history of the Medicare provisions of the Act indicates that Congress sought to avoid a two-tiered health care system for the elderly by seeing that providers receive adequate payment, and concluded that denying service providers recovery of their full Medicare rate would undermine that purpose by discouraging doctors and hospitals from treating dual eligible patients and QMBs. *Id.* at 11a.

The court also found support for its holding in the Medicaid provisions of the Social Security Act. Under Medicaid, a state plan must make funds

available for "medicare cost sharing" for QMBs (42 U.S.C. 1396a(a)(10)(E)), and "medicare cost sharing" is defined to include Medicare Part B premiums, coinsurance, and deductibles (42 U.S.C. 1396d(p)(3)). Pet. App. 11a-12a. The court rejected the Secretary's argument that 42 U.S.C. 1396a(n), which *permits* a state Medicaid plan to provide for more assistance to QMBs than would be available under Medicaid, would be a nullity if the other provisions were interpreted to *require* the States to furnish payment of 100% of all reasonable charges. The court believed that Section 1396a(n) merely clarifies that a service provider will not be penalized for accepting more than the Medicaid amount. Pet. App. 12a-13a.

The court refused to credit legislative history accompanying a 1989 amendment to the Medicare program that recognized that some States (like New York, following promulgation of the 1987 regulation at issue) do not reimburse for reasonable charges in excess of 80% of the Medicare Part B rate, to the extent the excess would be beyond the fee payable under Medicaid. Pet. App. 15a-16a. In addition, the court concluded that the Secretary's position was not entitled to deference because the Department had stated in 1981 that a service provider could seek reimbursement for the 20% coinsurance payment from a Medicaid patient enrolled by the State in Medicare Part B. *Id.* at 18a.

Judge Cardamone dissented. He stressed that nothing in the Medicare or Medicaid provisions of the Social Security Act speaks directly to whether dual eligible patients and QMBs should be treated primarily as Medicare or Medicaid patients. Pet. App. 21a-23a. In that circumstance, he would have deferred

to the Secretary's construction of the complex statutory scheme. *Id.* at 34a. With respect to the apparent change in position of the Department of Health and Human Services, Judge Cardamone noted that a district court decision, *Samuel* v. *California Dep't of Health Services*, 570 F. Supp. 566 (N.D. Cal. 1983), had intervened and supplied a reasoned basis for HHS's new position. Pet. App. 31a-32a.

ARGUMENT

In our view, the court of appeals reached the wrong result in this case. But we do not think that the question presented warrants review by this Court at this time.

As this Court has recognized, "[t]he Social Security Act is among the most intricate ever drafted by Congress." *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 43 (1981). The dissenting judge correctly pointed out that the Act's provisions do not clearly state whether dual eligible patients and QMBs should be treated primarily as Medicaid patients or as Medicare Part B patients. In that setting, the Secretary of Health and Human Services reasonably construed the Act to allow the regulation New York adopted in 1987. That regulation is premised on the view that dual eligible patients and QMBs are primarily Medicaid patients, a view that is entirely reasonable in light of the fact that they are enrolled by the State in Medicare Part B only because they are needy. In other words, it makes sense to look to the Medicaid statute in determining the government's obligations on behalf of needy patients.

Moreover, Congress ratified the Secretary's construction of the Act in 1989. At that time, Congress

enacted 42 U.S.C. 1395w-4(g)(3)(A) (Supp. II 1990), which provides that "[p]ayment for physicians' services" to dual eligible patients and QMBs "may only be made on an assignment-related basis." Congress explained that because "the Medicaid rules that result in assignment being accepted for all dual eligibles are not applicable to qualified Medicare beneficiaries * * *, physicians are able to bill these patients directly and to charge amounts in excess of what Medicare determines to be reasonable and what Medicaid will reimburse." H.R. Rep. No. 247, 101st Cong., 1st Sess. 364 (1989). At the same time, Congress recognized that state Medicaid programs "typically pay the Medicare coinsurance only to the extent that their payment, plus the Medicare payment, does not exceed what the Medicaid program would pay for the service." *Ibid.* Congress specifically stated that the amendment "*codifies* the current practice with respect to dual eligibles and extends it to qualified Medicare beneficiaries." *Ibid.* (emphasis added).

Finally, the Secretary's construction of the regulation works no unfair hardship on doctors and hospitals. Under the New York regulation at issue, they always receive the Medicaid fee for treating a needy patient. Sometimes—if 80% of the "reasonable charges" under Medicare Part B exceeds the Medicaid fee—they receive more than they would if the State had not enrolled the patient in Medicare Part B.

Nevertheless, we cannot say that this case warrants review by the Court at this time. The difference between the Medicaid fees for various services and the "reasonable charges" under Medicare Part B adds up to a substantial sum (see Pet. 7 &

n.4), more than half of which is paid by the federal government. But that sum still represents only a fraction of the total cost of the Medicaid program. In our view, the question presented would unquestionably be worthy of review by this Court if there were a conflict in the circuits. This case, however, represents the first time this complex issue of statutory construction has been decided by a court of appeals—indeed, by any court.* As petitioner notes (Pet. 11 n.6), other cases are already pending presenting the same question. We believe it would be appropriate to await further litigation developments before this Court addresses the issue.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

KENNETH W. STARR
Solicitor General

STUART M. GERSON
Assistant Attorney General

BARBARA C. BIDDLE
MARC RICHMAN
Attorneys

OCTOBER 1992

---

* Petitioner suggests (Pet. 8) that this case is comparable to *Simon & Schuster, Inc.* v. *Members of the New York State Crime Victims Bd.*, 112 S. Ct. 501, 508-509 (1991), and therefore warrants immediate review. But that case involved what was in effect a prior restraint on First Amendment activity.